CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155377	B. WIN			11/18/20	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ACKSON PARK DR		
SEYMOL	JR CROSSING				OUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000	Complaint IN000 IN00099962.  Complaint IN000 Federal/state def allegations are crand F226.  Complaint IN000 due to lack of even Survey dates: N 2011  Facility number: Provider number AIM number: 10 Survey team: Diana Sidell RN Janie Faulkner R  Census bed type SNF/NF: 79  Total: 79  Census payor type Medicare: 4  Medicaid: 69  Other: 6	ovember 16, 17, and 18,  000272 r: 155377 00274710  T, TC RN :		0000	PREPARATION AND/OR EXECUTION OF THIS PLAN CORRECTION IN GENERAL OR THIS CORRECTIVE ACT IN PARTICULAR, DOES NO CONSTITUTE AN ADMISSIO OR AGREEMENT BY THIS FACILITY OF THE FACTS ALLEGED OR CONCLUSION SET FORTH IN THIS STATEMENT OF DEFICIENCIES. The plan of corrective actions are preparently or executed in complian with state and federal laws. The facility is requesting a DESK REVIEW of complian for this plan of correction.	TION T DN NS of ared nce	
LABORATOR	LA DIDECTORIS OR PROJ	VIDED/CHIDDLIED DEDDECENTATIVE'S SI	a	-	TITI E		(V6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

P7G611

Facility ID:

000272

AND PLAN OF CORRECTION IDE		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	(X2) MULTIPLE CO  A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/18/2011		
		100011	B. WING	DDDDGG CVTV CT TT CT	11/10/2011		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR			
SEYMOU	IR CROSSING		SEYMOUR, IN47274				
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE		
1110	Total: 79	ESC IDENTIFICATION ORGANITION	ine		BATE		
	10111.						
	Sample: 7						
	These deficiencie	es reflect state findings					
		ce with 410 IAC 16.2.					
	Quality review co	ompleted 11/28/11 by					
	Jennie Bartelt, R	N.					
F0223 SS=D The resident has the right to be to verbal, sexual, physical, and me corporal punishment, and involuing seclusion.		ysical, and mental abuse,					
	sexual, or physica punishment, or inv	oluntary seclusion.	F0222		12/17/2011		
		review and interview, the	F0223		12/17/2011		
	_	ensure residents were exual abuse by another					
	resident and by s	taff. The deficient		F-223 Free from abuse/ involunta seclusion	iry		
	related to abuse i	3 of 5 residents reviewed n a sample of 7.		The facility's intent is to maintain	an		
		and G) Resident F was		environment free from abuse/			
		by Resident B, the		involuntary seclusion.			
	-	ensure Resident B was at					
	the Nurse's Statio	on as planned, and					
	Resident B subsequently sexually abused Resident A. Resident G was not protected from sexual abuse by CNA #1.			A. ACTIONS TAKEN:			
	Findings include	:		<ol> <li>Resident indicated is no lon a resident at the facility.</li> </ol>	ger		
	1. Resident 'F's r	record was reviewed on		<ol><li>Employee indicated was terminated.</li></ol>			

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	155377	A. BUI	LDING	00	11/18/2	
		133377	B. WIN			11/10/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR		
SEYMOU	JR CROSSING		SEYMOUR, IN47274				
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TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		p.m. The record					
		nt 'F' was admitted with					
	_	cluded, but were not			B. OTHERS IDENTIFIED:		
	· ·	ntia with mood and					
		ances, chronic back pain,					
	and high blood p	ressure.					
					1. All residents have the		
	A quarterly mini	mum data set assessment			potential to be affected.		
	dated 7/14/11 inc	dicated Resident 'F' was			Resident interviews compl	eted	
	severely impaire	d - never/rarely made			to ensure that they felt safe in th	eir	
	decisions in cogn	nitive skills for daily			home as well as free from abuse		
	decision making						
					3. 100% audit of the behavio	r	
	Nurse's notes dat	red 10/30/11 at 1:00 p.m.			monitoring record completed to identify any other residents with		
	indicated: "App	roximately 11:50 AM,			sexual behaviors towards other		
		d this writer stating she			residents or staff.		
		nt [with] both hands on					
		. States immediately			4. All staff in-service on, abus	e	
		r room. Assessed res			prohibition, reporting, and		
	[no] apparent inj				procedure as well as identifying a		
	encounter"	ures noted from			monitoring inappropriate behavi scheduled on 12/13/11 by ADNS	ors	
	cheodiner				/SSD or designee with a post test		
	Social service fo	llow up on 10/31/11			, 132 o. designed with a post test	-	
		nt 'F' was not afraid of					
		cility, said her weekend					
	•	and been placed on 15			C. MEASURES TAKEN:		
	minute checks fo	*					
	minute checks ic	01 /2 HOUIS.					
	A Facility man and	form to the ICDII			Any residents identified, call	are	
		form to the ISDH			plans / CNA. assignment sheets a	nd	
	`	epartment of Health),			current interventions will be		
	· ·	ndicated: "Immediate			reviewed/ updated.		
		Residents immediately			2 All chaff in an index are		
		o toe assessments			All staff in-service on, abuse prohibition, reporting, and	e	
	completed on bo	th residents. DNS/ED			promonuon, reporting, and		

000272

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	OO	COMPL	
ANDILAN	OF CORRECTION	155377		LDING	00	11/18/20	
		100077	B. WIN			11/10/2	311
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR		
SEYMOU	JR CROSSING				OUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	_	sing Services/Executive			procedure as well as identifying a monitoring inappropriate behavio		
	_	nt family, physicians			scheduled on 12/13/11 by ADNS	,,,	
		tive measures taken:			/SSD or designee with a post test	,	
	_	aced on 15 min checks			this will be completed on a mont	nly	
	_	esident 'B'] moved to			basis until discontinued by facility	′	
		center on another unit.			QA committee.		
	-	remain at nurse's station			Other employee involved in	1	
		m and under direct			incident has had 1:1 education		
	_	aff while away from unit.			regarding resident safety and		
	_	nns and CNA assignment			communication.		
	_	Social services to follow					
	up with both resi	dents for 72 hours."			<ol><li>Behavior monitoring tools be reviewed with IDT team daily</li></ol>	Will	
	TEI : .: .:				during daily clinical QA meeting.		
	_	n included a signed			adimg daily comidal & timesting.		
		CNA #6 dated 10/30/11 at			5. Resident incidents will be		
		esident 'B'] was in B -			reviewed daily during daily clinica		
	"	h [Resident 'F']. I came			QA meeting to implement / revie	w/	
		ng down meal intakes,			update any care plans and CNA.		
		] had both hands on			assignment sheets or intervention	15.	
	[Resident 'F's] br				6. Audit across all shifts by		
	[Resident 'F'] and	d informed Nurse."			charge nurse or designee to mon	itor	
					staff - resident interaction for		
		record was reviewed on			appropriateness continued until		
		p.m. The record			discontinued by CQI committee.		
		nt 'A' was admitted with					
	_	cluded, but were not					
	limited to, hearing	ig impairment, high					
	blood pressure, d	lementia, mild cognitive					
	impairment, deli				D. <b>HOW MONITORED</b> :		
	multi-etiology, a	nd agitated depression.					
		mum data set assessment			Resident interviews will be		
		dicated Resident 'A' was			completed to monitor for		
	able to make self	funderstood and			compliance. Also random emplo	yee	

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THIDTEM	or conduction	155377		LDING		11/18/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF I	PROVIDER OR SUPPLIEF	₹			ACKSON PARK DR	
SEYMOU	JR CROSSING				DUR, IN47274	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	understands other	ers, had minimal difficulty			audits will be completed to ensur	re e
	hearing, used a h	nearing aid, and was			staff compliance and understand	=
	moderately impa	aired - decisions poor;			of abuse prohibition policy by the	2
		required in cognitive			SSD/designee weekly x4 then	
	skills for daily d				monthly x2 then quarterly x3 to	00/
	Skills for dully d	coision making.			monitor for compliance and if 10	
	Numania motos do	tod 11/2/11 at 6.25 m m			of threshold not met actions plan will be developed.	S
		ted 11/3/11 at 6:35 p.m.			wiii be developed.	
		ed to resident room to			Any inappropriate behavio	rs
	_	'] in bed [with] resident			will be reported to the nurse ther	
		ere down to ankles and			reviewed in the daily clinical QA	
	his pants were d	own but depends were on			meeting.	
	both residents w	ere embracing each other				
	& making move	ments with their lower			3. Abuse prohibition and	
	bodies. Residen	ts were separated.			investigation, Abuse prohibition,	
		the does not know how			psychoactive medication/ behavi	or
		wn. Male resident thinks			management CQI tools will be	
		Male resident moved to			utilized by CEO/designee weekly	
					then monthly x2 then quarterly x to monitor for compliance and if	3
	another wing &				100% of threshold not met action	ns
	-	d to toe assessment done			plans will be developed.	
		vitals wnl (within				
	normal limits) [r	= ' <del>=</del>			4. The Executive	
		stress. Male resident had			Director/Designee will monitor fo	or
	been observed at	t nurse's station at 1820			compliance of audits in the daily	QA
	(6:20 p.m.)"				stand-up meeting.	
					C All andit results will be	
	A "Report of Inc	eident /Crime," dated			5. All audit results will be reviewed in the quarterly QA	
	11/4/11, indicate	ed: "Brief Description			meeting with the Medical Directo	nr.
	of Incident: Res	sident ['B'] was found in			meeting with the Medical Directo	
	bed with residen					
		None Immediate Action				
					E. This plan of correction	
	Taken: Residents separated, head to toe assessments completed on both residents.				constitutes our credible allegation	
		-			of compliance with all regulatory	<i>'</i>
		nt family, and physicians			requirements, out date of	
	notified. Preven	tive measures taken:			completion is:	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155377		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  11/18/2011	
			. W IIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMO	UR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	ΓE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)  [Pasident 'A'] was placed on 15 min			TAG	DEFICIENCY)		DATE
	[Resident 'A'] was placed on 15 min checks for 72 hours and [Resident 'B']				12/17/11.		
		1 supervision and moved					
	_	Resident care plans					
		nt 'B'] sent to behavioral					
	_	11/4/11. Abuse training					
	to be completed	· ·					
	to be completed	ioi un suii.					
	The facility inve	stigation of this incident					
	included a writte	n and signed statement					
	from RN #4: "W	as working C-wing with					
	(two CNAs) - [R	esident 'B'] on 15 minute					
	checks for recen	t incident of sexual					
	misconduct [witl	n] female resident was					
	moved to this wi	ng R/T (related to)					
	incident. At 182	0 (6:20 p.m.) [Resident					
	'B'] was at nurse	s desk observed by nurse					
	& CNA's. I told	CNA's was going to take					
	10 minute break.	7 minutes later was					
	1	<sup>‡</sup> 5] to C wing. Came					
		that while CNAs where					
		ther resident] down					
		d wheeled self to					
	-	oom and was in bed with					
		(sic) [name of roommate]					
		to get nurse because there					
		an in bed with her					
	, ,	parking like a dog. [LPN					
	_	oom at 1835 (6:35 p.m.)					
		lents with pants down to					
	_	nt 'A'] had depend on. I					
		sidents embracing each					
		& moving lower bodies					
	as if having sex	no penetration was					

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P7G611 Facility ID:

ty ID: 000272

If continuation sheet

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		155377		LDING		11/18/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			ACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMO	UR, IN47274		
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TAG		bservedwe separated residents and			DEFICIENCY)		DATE
		s to ensure safety. DON					
	_	sing] & social services all notified. Head to toe					
	-	ne on both [no] injuries.					
		ought [Resident 'A'] was					
		ent 'B'] was taken to D					
	wing and put on	_					
	supervision"	one a one					
	Super vision						
	The facility inve	stigation included a					
	_	ed statement from LPN					
		On this date at 1835 (6:35					
	p.m.) I was work	,					
	- '	[Resident 'A's roommate]					
	_	and asked if I was the					
		ng". I informed her I was					
		hat she needed. She then					
	*	t "There is a strange man					
	in my room and	he is in bed with my					
	room mate." I ir	nmediately went to room					
	[number of room	n] where I found					
	[Resident 'B'] lay	ying in bed with [Resident					
	'A']. I immediate	ely paged "C-Wing nurse					
	[RN #4] to room	. Upon arrival to room I					
	_	ident 'B' and Resident 'A']					
	undressed from t	the waist down.					
	[Resident 'B'] wa	as still wearing a depends					
	-	d aside so as to appear it					
	had been remove	ed. Together [RN #4]					
	removed [Resident 'B'] from bed, dressed						
	him, placed him	in W/C and placed him at					
		ith CNA. Head to toe					
	performed imme	diately and incident					

AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155377		LDING	NSTRUCTION  00	(X3) DATE COMPI 11/18/2	LETED	
	PROVIDER OR SUPPLIER	2	STREET A	ODDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR UR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)  Posident [IDI] was	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	_	Resident ['B'] was bom by approximately )."				
	visited [with Resistting in chair string in chair string in chair string in chair string in chair string. Writer any visitors last "No". Writer incouched her in at voices "No". Writer incouched her in at voices "No". Writer incouched her in at facility voices noted - pleasant,  On 11/17/11 at 3 Services Director has shown no significated at any time.  3. Resident 'B's 11/17/11 at 11:0 indicated Resided diagnoses that in limited to, high binsulin depender.	3:30 p.m., the Social or indicated Resident 'A' gns of distress from this				
	An admission as	sessment dated 8/26/11				

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155377			LDING	NSTRUCTION 00	î ´	SURVEY LETED 2011	
	PROVIDER OR SUPPLIED	R	<u> </u>	707 S J	DDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR UR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	O BE	(X5) COMPLETION DATE
	understood, usua was moderately cues/supervision skills for daily dacute change in resident's baselindirected toward  Nurse's notes witimes indicated: - 10/30/11 at 11: CNA reported to Res breasts. Res 15 min [checks] - 10/30/11 at 1:00 combative this dassist up X2 - slakept reaching our rendering care slap & grab staff - 11/3/11 at 2:40 min [checks], in - 11/3/11 at 6:35 number for resident my room and my room mate."  Wing and upon this resident [with] resident [	th the following dates and  245 a.m.: "Res found by o nurse [with] hands on s's immediately separated. started immediately."  20 p.m.: "Res's move o Wing for safety"  20 p.m.: "Res very lay - staff attempted to apped CNA in face & att to grab & hit staff while grabbing at staff trying to					

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	PROVIDER OR SUPPLIER JR CROSSING		<u> </u>	707 S J	DDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR UR, IN47274		
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	still had brief on, resident. Reside & C Wing nurse transferring to we combative, reside cuddle [with] my - 11/3/11 at 6:50 notified of above [physician's nam [to] behavioral u Wing for one to toe [assessment] - 11/4/11 at 1:50 facility] here to the facility]"  A care plan dated "Resident touched in appropriately of Resident will have behaviors TNR (Interventions(2) Wing for safety. hours(6) Resident will have behaviors to be provided by the A care plan dated updated care plan regarding this resident with female peer with female peer transfer or the safety and the safety are plan dated updated care plan regarding this resident with female peer with female peer transfer or the safety and the safety are plan dated updated care plan tregarding this resident with female peer with female peer transfer or the safety and the safety are plan dated updated care plan tregarding this resident with female peer with female peer transfer or the safety and the safety are safety as the s	p.m.: "Family & MD [physician] on call for [physician] on call for [physician] on call for [physician] on call for [prequested order to send [physician] on call for [physicia					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155377			LDING	NSTRUCTION  00	(X3) DATE ( COMPL 11/18/2	ETED		
	PROVIDER OR SUPPLIEF	₹	STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN47274					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
TAG	On 11/17/11 at 4 Health Services had seen Resider address behavior remember bits at exact events.  On 11/17/11 at 4 Director indicate to another room incident on 11-3  4. Resident 'G's 11/18/11 at 12:3 indicated Reside diagnoses that in limited to, high I weakness, insomanxiety.  A quarterly minimated 10/14/11 in clear speech, manunderstands other independence in decision making	A:25 p.m., the Director of indicated Psych services nt 'B' on 9/14/11 to rs and Resident 'B' could nd pieces, but didn't recall A:25 p.m., the Executive ed they "had moved him on another hall after the -11 with [Resident 'A']."  Trecord was reviewed on 0 p.m. The record ent 'G' was admitted with included, but were not blood pressure, left sided innia, depression, and imum data set assessment indicated Resident 'G' had ide himself understood, ers, and had modified cognitive skills for daily includes dated 10/7/11 at		TAG	DEPICIENCY		DATE	
	time as to any co	[with Resident 'G'] at this oncerns related to his care. pices, on 10/6/11 around						

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AND PLAN	OF CORRECTION		MBEK:	A. BUIL	DING	00		COMPL	
		155377		B. WINC	_			11/18/2	011
NAME OF F	PROVIDER OR SUPPLIER					DDRESS, CITY, STA	*		
CEV/MO!	ID CDOSCINO					ACKSON PARK	DR		
	JR CROSSING					UR, IN47274			
(X4) ID		TATEMENT OF DEFICI			ID		LAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCED! LSC IDENTIFYING IN		ì	PREFIX	CROSS-REFERENCE	E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)	E	COMPLETION
TAG				+-	TAG	DEFF			DATE
	5PM - he was in		•						
	his bottom and a		cea 11 -						
	resident voices it		mt it to						
	uncomfortable.								
	happen again. R								
	want any one in								
	provided and ass		would						
	be investigated	"							
	]	1.10 = 11.1							
	A care plan dated								
		patted on my bo							
		me feel uncomfor							
	Goal: I will be c	comfortable in my	y care						
	TNR (through ne	ext review) Inter	ventions:						
	(1) Reassure (2)	Encourage to ver	nt						
	feelings (3) Noti	fy POA [power o	$\circ f$						
	attorney], MD. (4	4) Resident and F	POA						
	does not wish to								
	environment (6)	•	*						
	to care"	1 1							
	A "Facility Incid	lent Reporting Fo	rm"						
	dated 10/7/11 inc								
	Description of In		21						
	reported during of	-	-						
	[Resident 'G'] on								
	Injury/Injuries: N	-	-						
	Taken: [CNA #1		/ 1 CHOII						
	immediately susp		a talram:						
	investigation. Pro								
	Shift to Shift 100		vice on						
	Abuse and Repor	<del>-</del>							
	immediately. Re	_							
	Investigation cor	nplete, Staff state	ements,						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete	Event ID: P	7G611	Facility I	D: 000272	If continuation sh	neet Par	ge 12 of 46

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155377		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/18/2011		
	PROVIDER OR SUPPLIEF	R	· ·	STREET A	DDRESS, CITY, STA ACKSON PARK UR, IN47274			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NOWN MUST BE PERCEDED BY FERLED BY FERLED BY FERLED BY FERLED BY FORMA	TULL	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	PLAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE CICIENCY)	<u>:</u>	(X5) COMPLETION DATE
	resident intervier reported at the enurse that at app witnessed [CNA the buttocks and and proceeded to buttocks. After did state he did again. Plan of A [CNA #1 and 2] and Abuse Inser  The facility inversinct included a writter from LPN #3: "  @ approx. 9:55 needed to talk [view drsg. change on completed my tastation and began after, [CNA #2] nurse's station are went to her. She knew she was sure asked her what view by telling me that sexual gestures to while they were began smacking then asked him is said yes, she did was as if she was look came over [#2] when this had	ws collected. [CNA #2 nd of her shift at 10 pm proximately 4:30 pm shat #1] pat [Resident 'G'] asked him if he liked it pat him again on the interviewing resident, hot want it to happen action/Interventions: to both be terminated, vicing."  estigation of this incider en and signed statement [CNA #2] informed me p.m. (10-6-11) that she with] me while doing a a resident. After I ask, I went to nurse's in giving report. Shortly came to door way of and stood. I got up and the began telling me she appose to report this. I awas going on. She began tel [CNA #1] had made to [Resident 'G']. Said changing him, [CNA # him on the buttocks. Sa if he liked it and when I att again. Said at first i s joking, then a serious the face. I asked [CNA appened and she replied	to e on t t e e e e e e e e e e e e e e e e e					
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete Eve	nt ID: P7G61	1 Facility I	D: <b>000272</b>	If continuation she	et Pac	ge 13 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377			LDING	NSTRUCTION  00	(X3) DATE COMPL 11/18/2	ETED
	PROVIDER OR SUPPLIE	R	 707 S J	DDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR UR, IN47274	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	[CNA #2] that soon as it happe care of then, do shift. Told [CN statement. Took DON @ that time.  A signed statem indicated: "[CN gesture toward [smacked him on were changing hiked it"? He the "oh really, can I she did. I witne pm."  A signed statem indicated: "I was over to change he for bed. Normal is screaming and hurting him. We [night] he was no gently patted or asked him if I we no to do it again wasn't going to to I am turning you to turn you and you was no shift in the soon	ent from CNA #2 [A #1] made a sexual [Resident 'G']. She is the buttox (sic) while him and asked him "if he en said yes, and she said do it again then?" And ssed this at approx. 4:30  ent from CNA #1 as turning [Resident 'G'] him. And get him ready lly whenever I turn him he d hollering that I am as surprised that last nite ot doing any of that. I tapped his buttocks, & I ras hurting him. He said but I told him no that I do it. But [Resident 'G'] if and using the draw sheet you are screaming & that I am hurting you, why				

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377		LDING	NSTRUCTION  00	(X3) DATE COMPI 11/18/2	LETED
	PROVIDER OR SUPPLIER		B. WIIV	STREET A	DDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR UR, IN47274	-1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	Reporting, and In Procedure" with 10/17/11, was pr Director on 11/1 policy indicated, "It is the policy of Communities to abuse including pabuse, verbal abuneglect, involunt misappropriation and/or fundsSe is not limited to, sexual coercion, American Senior permit residents by anyone, incluresidents, consul	d "Abuse Prohibition, avestigation Policy and an effective date of ovided by the Executive 7/11 at 10:12 a.m. The but was not limited to: of American Senior protect residents from physical abuse, sexual asse, mental abuse, ary seclusion, and of resident property xual Abuse - includes but sexual harassment, or sexual assault1.  Communities will not to be subjected to abuse ding employees, other tants, volunteers"					

	OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	A. BUILDIN	IPLE CONST NG -	00	COMPLET 11/18/201	ED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  707 S JACKSON PARK DR  SEYMOUR, IN47274					
(X4) ID PREFIX TAG	(EACH DEFICIEN	CATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE (	(X5) COMPLETION DATE	
F0224 SS=D	written policies and mistreatment, negland misappropriate Based on record facility failed to chistory of inapprowith staff was ideplanned and implement the residents of the residents. affected 3 of 5 reto allegations of 7. (Residents had a history of i	emented interventions to ent from sexually abusing The deficient practice sidents reviewed related sexual abuse in a sample B, F and A) Resident B nappropriate sexual ff and sexually abused	F0224		F-224 Prohibit mistreatment/ neglect/ misappropriation  The facility's intent is to maintain and the servironment free from mistreatment/ neglect/ misappropriation.  A. ACTIONS TAKEN:		12/17/2011	
	11/17/11 at 11:05	record was reviewed on 5 a.m. The record nt 'B' was admitted with		F 1	<ol> <li>Resident was immediately placed on under 1:1 supervision until being transferred out of facility.</li> <li>Resident indicated is no long</li> </ol>			
	diagnoses that inclimited to, high binsulin dependen	cluded, but were not lood pressure, non			a resident at the facility.  B. OTHERS IDENTIFIED:			

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155377				LDING	00	(X3) DATE COMPL 11/18/2	ETED
	PROVIDER OR SUPPLIEF	<u>l</u>	STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN47274				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	Resident 'B' make usually understar moderately impactues/supervision skills for daily described acute change in a resident's baselind directed toward assistance of one and transfers, did independent with locations in his recorridor and to a the floor in a whole where the second independent with locations in his recorridor and to a the floor in a whole where indicated:  On 8/19/11 at 1 assist. res to B/R to bed res inapper gown up & shoother if she had evidence before these these before the second the these before th	d 8/26/11 indicated tes self understood, ands others, was aired - decisions poor; a required in cognitive ecision making, had an amental status from the ne, had behaviors not others, required extensive experson for bed mobility d not walk, and was a moving between room and adjacent and from distant areas on eelchair.  The following dates and the following dates an			1. All residents have the potential to be affected.  2. Resident interviews completed to ensure that they felt safe in thome as well as free from mistreatment, neglect / misappropriation.  3. 100% audit of the behaving monitoring record completed to identify any other residents with sexual behaviors towards other residents or staff.  4. All staff in-service on, about prohibition, reporting, and procedure as well as identifying monitoring inappropriate behaves scheduled on 12/13/11 by ADN /SSD or designee with a post test current interventions will be reviewed/ updated.  2. All staff in-service on, about prohibition, reporting, and procedure as well as identifying monitoring inappropriate behaves current interventions will be reviewed/ updated.  2. All staff in-service on, about prohibition, reporting, and procedure as well as identifying monitoring inappropriate behaves cheduled on 12/13/11 by ADN	or o h use gand viors S st.  care and	
	mappropriate, w	in nonly 55.			<u>' ' '</u>		

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	00	(X3) DATE SURVEY  COMPLETED
THEFTERN	or conduction	155377		LDING		11/18/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				ACKSON PARK DR	
SEYMOL	JR CROSSING				DUR, IN47274	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG		45 a.m.: "Res found by		IAG	/SSD or designee with a post test,	DAIL
		nurse [with] hands on			this will be completed on a month	ıly
	•	's immediately separated.			basis until discontinued by facility	·
		started immediately."			QA committee.	
		0 p.m.: "Res's move			2 Other condense involved in	
		Wing for safety"			<ol><li>Other employee involved in incident has had 1:1 education</li></ol>	
	- 11/1/11 at 1:00	· ·			regarding resident safety and	
		ay - staff attempted to			communication.	
		apped CNA in face &				
	•	t to grab & hit staff while			4. Behavior monitoring tools v	vill
		grabbing at staff trying to			be reviewed with IDT team daily during daily clinical QA meeting.	
	slap & grab staff				daring daily chilical covinceting.	
		a.m.: "Remains on 15			5. Resident incidents will be	
		bed resting quietly"			reviewed daily during daily clinica	
		p.m.: "Resident [facility			QA meeting to implement / review	v/
		ent] approached this			update any care plans and CNA. assignment sheets or intervention	
		"There is a strange man			assignment streets of intervention	
		he is laying in bed with			6. Audit across all shifts by	
	_	I immediately left D			charge nurse or designee to monit	tor
	Wing and upon e	entering room [number]			staff - resident interaction for	
	this resident was	found laying in bed			appropriateness continued until discontinued by CQI committee.	
	[with] resident [f	acility number for			,	
	resident]. Paged	C-Wing nurse to room.				
	Residents were s	eparated. This resident				
		assisted with redressing				
		nt able to stand this nurse			D. <b>HOW MONITORED</b> :	
		assisted resident with				
		/c due to resident being				
		ent stating "I just want to			Resident interviews will be	
	cuddle [with] my				completed to monitor for	
		p.m.: "Family & MD			compliance. Also random employ	vee
		[physician] on call for			audits will be completed to ensure	
		e] requested order to send			staff compliance and understanding	ng
	[to] behavioral u	nitresident moved to D			of abuse prohibition policy by the	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155377		LDING	ONSTRUCTION  00	(X3) DATE : COMPL 11/18/2	ETED	
SEYMOU (X4) ID		TATEMENT OF DEFICIENCIES	707 S J SEYMO	ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR DUR, IN47274  PROVIDER'S PLAN OF CORRECTION		(X5)
	SUMMARY S (EACH DEFICIENT REGULATORY OR Wing for one to toe [assessment] - 11/4/11 at 1:50 facility] here to to facility]"  A social service indicated: "M. female staff and staffsocially in noted, recent one Social Service N 8:00 a.m., indicated admitted to [psydue to increased and very involved A care plan, date have Behaviors phitting caregiver have Diagnosis: Goal: My Behave directed with selection of the [tint] I will have no in the second	one supervision. Head to completed"  p.m.: "[Name of transport Res to [another assessment dated 8/27/11 aking sexual comments to exposing self to appropriate behaviors set"  Jotes, dated 9/20/11 at teed: "[Resident B] chiatric hospital] 9/19/11 behaviors, family aware	SEYMO	DUR, IN47274	on or and or x4 3 as or QA	(X5) COMPLETION DATE
	my status 2. Med My Md5. Psyc request12. Cal	erve me for changes in dications as ordered per the services per my mapproach calm 4. Provide education as to ecepting care."		12/17/11.		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377		ULTIPLE CO LDING	NSTRUCTION 00	COM	TE SURVEY PLETED /2011
		155377	B. WIN				/2011
	PROVIDER OR SUPPLIEF	3		707 S J	DDRESS, CITY, STATE, ZIP CO ACKSON PARK DR JUR, IN47274	DE	
				<u> </u>			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO	CTION	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	COMPLETION DATE
IAU		*	+	TAG			DATE
		ed 10/31/11, indicated					
	"Resident touche	•					
	11 1	on 10/30/11. Goal:					
		ve not further inapprop.					
	· ·	through next review).					
	`	2) temporarily move to D					
	1 -	(3) 15 min [checks] X 72					
	` ′	o remain @ nurses station					
		m. (7) direct supervision					
	to be provided by	y staff when off the unit."					
	A care plan, date	ed 11/4/11, indicated an					
	updated care pla	n for the episode					
	regarding this re	sident observed in bed					
	with female peer	, and included the					
	intervention to se	end Resident 'B' to a					
	behavior unit.						
		:25 p.m., the Director of					
		indicated Psychiatric					
	services had seen	n Resident 'B' on 9/14/11					
	to address behav	iors and Resident 'B'					
	could remember	bits and pieces, but didn't					
	recall exact even	its.					
	On 11/17/11 at 4	25 p.m., the Executive					
		ed they "had moved him					
		on another hall after the					
		-11 with [Resident 'A']."					
	2. Resident 'F's	record was reviewed on					
		p.m. The record					
		nt 'F' was admitted with					
		cluded, but were not					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155377				LDING	NSTRUCTION  00	(X3) DATE COMPI 11/18/2	LETED
	PROVIDER OR SUPPLIEI	·	•	707 S J	DDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMO	UR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  ICY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	· · · · · · · · · · · · · · · · · · ·	ntia with mood and ances, chronic back pain, pressure.					
	dated 7/14/11 in severely impaire	imum data set assessment dicated Resident 'F' was ed - never/rarely made nitive skills for daily					
	Nurse's notes dated 10/30/11 at 1:00 p.m. indicated: "Approximately 11:50 AM, CNA approached this writer stating she saw male resident [with] both hands on resident's breasts. States immediately moved Res to her room. Assessed res [no] apparent injuries noted from encounter"  Social service follow up on 10/31/11 indicated Resident 'F' was not afraid of anyone in the facility, said her weekend was "fine", and had been placed on 15 minute checks for 72 hours.						
	(Indiana State D dated 10/31/11, Action Taken: I separated, head completed on bo [Director of Nur Director], reside	t form to the ISDH epartment of Health), indicated: "Immediate Residents immediately to toe assessments oth residents. DNS/ED sing Services/Executive nt family, physicians tive measures taken:					

PRINTED: 12/19/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMP 11/18/2	LETED
		199377	B. WIN				2011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD ACKSON PARK DR	E	
SEYMOU	JR CROSSING			SEYMO	UR, IN47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)		COMPLETION
TAG		aced on 15 min checks		TAG	DEFICIENCE		DATE
	•	esident 'B'] moved to					
	_	center on another unit.					
		remain at nurse's station					
	_	n and under direct					
		aff while away from unit.					
		ans and CNA assignment					
	_	Social services to follow					
	_	dents for 72 hours."					
	_						
	The investigation	n included a signed					
	statement from C	CNA #6 dated 10/30/11 at					
	12:00 p.m.: "[Re	esident 'B'] was in B -					
	Wing lounge wit	h [Resident 'F']. I came					
	in to finish writir	ng down meal intakes,					
	and [Resident 'B'	] had both hands on					
	[Resident 'F's] br	east. I removed					
	[Resident 'F'] and	d informed Nurse."					
	3. Resident 'A's	record was reviewed on					
	11/17/11 at 2:31	p.m. The record					
		nt 'A' was admitted with					
		cluded, but were not					
		ng impairment, high					
	_	lementia, mild cognitive					
	impairment, deli						
	multi-etiology, a	nd agitated depression.					
	A quarterly mini	mum data set assessment					
		dicated Resident 'A' was					
	able to make self	funderstood and					
	understands othe	rs, had minimal difficulty					
	•	earing aid, and was					
	moderately impa	ired - decisions poor;					

Facility ID:

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	LDING	NSTRUCTION 00	(X3) DATE COMPL 11/18/2	ETED
	PROVIDER OR SUPPLIER		STREET A	ODDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR UR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	cues/supervision skills for daily do	required in cognitive ecision making.				
	indicated: "Calle find resident ['B' ('A') her pants were do both residents we a making mover bodies. Resident states sher pants got down she is his wife. I another wing a supervision head on [Resident 'A'] normal limits) [In symptoms] of disbeen observed at (6:20 p.m.)"	to toe assessment done vitals wnl (within o) s/s (signs or stress. Male resident had nurse's station at 1820				
	11/4/11, indicate of Incident: Res bed with residen Injury/Injuries:	None Immediate Action				
	assessments com DNS/ED, resider notified. Preven [Resident 'A'] wa checks for 72 ho	es separated, head to toe apleted on both residents. In family, and physicians tive measures taken: In as placed on 15 min and [Resident 'B']  1 supervision and moved				

	NT OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377		LDING	NSTRUCTION  00	(X3) DATE COMP 11/18/2	LETED
	PROVIDER OR SUPPLIEF	<b>.</b>	J. WII.	STREET A	DDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR UR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE	(X5) COMPLETION DATE
	to another unit. update. [Reside: health center on to be completed  The facility inveincluded a writte from RN #4: "V	Resident care plans nt 'B'] send to behavioral 11/4/11. Abuse training					
	checks for recen misconduct [with moved to this with incident. At 182 'B'] was at nurse	t incident of sexual h] female resident was ing R/T (related to) to (6:20 p.m.) [Resident to desk observed by nurse CNA's was going to take					
	paged by [LPN # back to discover (sic) laying [ano [Resident 'B'] ha	7 minutes later was 45] to C wing. Came that while CNAs where ther resident] down d wheeled self to boom and was in bed with					
	went to D wing was a strange maroommate (sic) by #5] went to the r	(sic) [name of roommate] to get nurse because there an in bed with her barking like a dog. [LPN boom at 1835 (6:35 p.m.)					
	ankles. [Resider observed both re other with arms as if having sex observedwe se took proper step	dents with pants down to nt 'A'] had depend on. I sident's embracing each & moving lower bodies no penetration was parated resident's and s to ensure safety. DON s all family members					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ·			NSTRUCTION 00		(X3) DATE COMPL	
		155377	A. BUII B. WIN				11/18/2	
			B. WIN		DDRESS, CITY, STATE	ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ACKSON PARK D			
SEYMOL	JR CROSSING				UR, IN47274	•		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN			(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED T DEFICIE	O THE APPROPRIAT	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIE	NCY)		DATE
		o toe [assessment] done						
		rries. [Resident 'B']						
	1 -	nt 'A'] was his wife.						
		as taken to D wing and						
	put on one & on	e supervision"						
	The facility inve	stigation included a						
	1	ed statement from LPN						
		On this date at 1835 (6:35						
	p.m.) I was work	· ·						
		[Resident 'A's roommate]						
		and asked if I was the						
		ng". I informed her I was						
		hat she needed. She then						
	· ·	t "There is a strange man						
		he is in bed with my						
	1	nmediately went to room						
	[number of room	•						
	_	ying in bed with [Resident						
		ely paged "C-Wing nurse						
		. Upon arrival to room I						
		-						
	_	ident 'B'] and Resident om the waist down.						
	_							
	1 -	as still wearing a depends						
		d aside so as to appear it						
		ed. Together [RN #4]						
	_	ent 'B'] from bed, dressed						
	_	in W/C and placed him at						
		ith CNA. Head to toe						
	_	ediately and incident						
	_	Resident ['B'] was						
		oom by approximately						
	1845 (6:45 p.m.)	)."						
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155377			LDING	NSTRUCTION 00	(X3) DATE COMP 11/18/2	LETED	
	PROVIDER OR SUPPLIER JR CROSSING		<u> </u>	707 S J	DDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR UR, IN47274	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE	(X5) COMPLETION DATE
	visited [with Ressitting in chair srinquired as to any smiling. Writer any visitors last in "No". Writer incouched her in ar voices "No". Writer any visitors last in touched her in ar voices "No". Writer incouched her in ar voices "No". Writer incomplete as to if at facility voices noted - pleasant,  On 11/17/11 at 3 Services Director has shown no significated at any time. A document title Reporting, and In Procedure" with 10/17/11, was problem on 11/11 policy indicated, "It is the policy of Communities to abuse including plabuse, verbal abuneglect, involunt misappropriation and/or fundsSe	:30 p.m., the Social r indicated Resident 'A' ans of distress from this					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155377			(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COM	TE SURVEY  SPLETED  S/2011			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN47274						
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	Any individual versident-to-resident-to-resident-to-resident-to-resident immediately septimovel. 2. The witnessed the abstruction immediately supervisor4. Somaintain the resident under direct superinvestigation is considered in safety is maintain the resident in the	ent abuse will arate the residents e individual who use will report the ately to his/her taff member(s) will dent initiating the abuse ervision until the initial complete and resident							

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
		155377	A. BUII B. WIN		<del></del>	11/18/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ACKSON PARK DR		
SEYMOL	JR CROSSING				UR, IN47274		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0225 SS=D	have been found gor mistreating resident have had a finding nurse aide registry mistreatment of resident of their property; a has of actions by a employee, which we service as a nurse	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or a entered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an evould indicate unfitness for a aide or other facility staff to de registry or licensing					
	violations involving abuse, including in and misappropriati reported immediat the facility and to c with State law thro	nsure that all alleged g mistreatment, neglect, or njuries of unknown source ion of resident property are ely to the administrator of other officials in accordance ough established procedures tate survey and certification					
	alleged violations	ave evidence that all are thoroughly investigated, further potential abuse while in progress.					
	reported to the addrepresentative and accordance with S State survey and c working days of the violation is verified action must be take Based on record facility failed to a	nvestigations must be ministrator or his designated it to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective en.  review and interview, the ensure staff reported an se immediately to the	F0	225			12/17/2011
	_	deficient practice sidents reviewed related			F-225 Investigate/ report allegations/ individuals		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155377				LDING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 11/18/2011
	PROVIDER OR SUPPLIER			707 S J	ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR DUR, IN47274	•
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	to allegations of abuse in a sample of 7. (Resident G) The facility also failed to ensure a resident being abused was				The facility's intent is to investiga report allegations/ individuals.	ite/
	protected from further abuse by immediate separation of the abuser (Resident B) from the abused resident (Resident A). This deficient practice				A. ACTIONS TAKEN:	
	affected 1 of 5 residents reviewed related to allegations of abuse in a sample of 7. (Resident A)  Findings include:				Employees indicated were suspended and did not return to facility.	
					Resident indicated is no load     a resident at the facility.	nger
	1. Resident 'G's record was reviewed on 11/18/11 at 12:30 p.m. The record indicated Resident 'G' was admitted with diagnoses that included, but were not limited to, high blood pressure, left sided				B. <b>OTHERS IDENTIFIED</b> :	
	anxiety.	nnia, depression, and			All residents have the potential to be affected	
	dated 10/14/11 i	mum data set assessment ndicated Resident 'G' had de himself understood,			Resident interviews compl     to ensure that they felt safe in th     home.	
	understands others, and had modified independence in cognitive skills for daily decision making.				<ol> <li>100% audit of the behavior</li> <li>monitoring record completed to</li> <li>identify any other residents with</li> <li>sexual behaviors towards other</li> </ol>	
	8:40 a.m. indicate Resident 'G'] at the concerns related 'G'] voices, on 10	fotes dated 10/7/11 at ted: "SS spoke [with this time as to any to his care. [Resident 0/6/11 around 5PM - he a CNA patted his bottom			residents or staff.  4. All staff in-service on, abus prohibition, reporting, and procedure as well as identifying a monitoring inappropriate behavischeduled on 12/13/11 by ADNS	and

INTERCATION NUMBER   155377   SACKSON PARK DESCRIPTION OF SACKSON PARK DESCRIPTION O	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(3) DATE SURVEY		
SEYMOUR CROSSING   STREET ADDRESS, CITY, STATE, ZIP CODE   TOTO S. JACKSON PARK OR   SEYMOUR, IN47274	AND PLAN	OF CORRECTION		A. BUII	LDING	00	COMPLETED
NAME OF PROVIDER OR SUPPLIER  SEYMOUR CROSSING  AND SUMMARY STATEMENT OF DEFICIENCIES  GEACH DEPETICINCY MUST BE PERCEDED BY PELL  REGULATORY OR LSC IDENTIFYING INFORMATION)  And asked him if he liked it - resident  voices it made him uncomfortable. And  he didn't want it to happen again.  Resident voices he didn't want any one in  trouble, reassurance provided and assured  his concern would be investigated"  A care plan, dated 10/7/11, indicated:  "Problem: I was patted on my bottom on  10/6/11 it made me feel uncomfortable.  Goal: I will be comfortable in my care  TINR (through next review) Interventions;  (1) Reassure (2) Encourage to vent  feelings (3) Notify POA [power of  attorney], MID. (4) Resident and POA  does not wish to press charges. (5) Calm  environment (6) explain procedures prior  to care"  A "Facility Incident Reporting Form"  indicated: "Brief Description of Incident:  [CNA #2] reported during care [CNA #1]  patted [Resident 'G'] on the buttocks.  Type of Injury/Injuries: None. Immediate  A Action Taken: [CNA #1 and CNA #2]  immediately suspended pending  investigation. Preventive measures taken:  Shift to Shift 100% all staff inservice on  A buse and Reporting initiated immediately. Results of Investigation:  Investigation complete, Staff statements, resident interviews collected. [CNA #2] reported at the end of her shift at 10 pm to			155377				11/18/2011
SEYMOUR CROSSING   SEYMOUR, INAT274   SEYMOUR, INAT274   (X5)   SEYMOUR, INAT274   (X5)   SEYMOUR, INAT274   (X5)   COMMETTON   TAG   REGULATORY FOR ISE PERCEDED BY FULL   TAG   REGULATORY FOR ISE DESTIFIENT (IN FORMATION)   TAG   RESIDENT (IN FORMATION)   T	NAME OF I	DROVIDED OD CUIDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
SUMMARY STATEMENT OF DEFICIENCIES   TO PRIFIX   CHACLI DEFICIENCY MISS IN PRIFIX   CHACLI DEFICIENCY MISS IN PRIFIX   PRIFIX   CHACLI DEFICIENCY MISS IN PRIFIX   TAG   REGULATORY FOR INFORMATION)   TAG   REGULATORY FOR INFORMATION   TAG   REGULATORY FOR INFOR	NAME OF I	PROVIDER OR SUPPLIER	C		707 S J	ACKSON PARK DR	
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resident interviews collected. [CNA #2] reported at the end of her shift at 10 pm to		immediately. Re	esults of Investigation:			• • •	<u>.</u>
resident interviews collected. [CNA #2] family will be notified.							
reported at the end of her shift at 10 pm to							iiu
						, 22 112411141	
		_				Resident safety will be maintaine	d at
I marke that at approximatory 7.30 pm she		_				Resident safetv will be maintaine	d at

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	155377		LDING	00	11/18/2011
		100077	B. WIN		A DDDEGG CITY CTATE TID CODE	11710/2011
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR	
SEYMOU	JR CROSSING				OUR, IN47274	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, and the second	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	+	,		TAG	all times. Non compliance with	DATE
	_	#1] pat [Resident 'G'] on			reporting and or protecting may	
	the buttocks and asked him if he liked it and proceeded to pat him again on the buttocks. After interviewing resident, he				result in disciplinary action up to	and
					including termination.	
		not want it to happen				
		action/Interventions:				
	_	to both be terminated,				
	and Abuse Inservicing."				D. <b>HOW MONITORED</b> :	
	The facility inve	estigation of this incident				
	included a writte	en and signed statement				
		[CNA #2] informed me			1. Resident interviews will be	
		p.m. (10-6-11) that she			completed to monitor for	
		vith] me while doing a			compliance. Also random employ	
	_	a resident. After I			audits will be completed to ensur staff compliance and understandi	
		ask, I went to nurse's			of abuse prohibition policy by the	
	station and bega	n giving report. Shortly			SSD/designee weekly x4 then	
	_	came to door way of			monthly x2 then quarterly x3 to	
		nd stood. I got up and			monitor for compliance and if 100	
		e began telling me she			of threshold not met actions plan	S
	knew she was su	ippose to report this. I			will be developed.	
		was going on. She began			Any inappropriate behavior	rs
		at [CNA #1] had made			will be reported to the nurse ther	n
	, ,	to [Resident 'G']. Said			reviewed in the daily clinical QA	
	while they were	changing him, [CNA #1]			meeting.	
	began smacking	him on the buttocks. She			Abuse prohibition and	
	-	f he liked it and when he			investigation, Abuse prohibition,	and
	said yes, she did	it again. Said at first it			psychoactive medication/ behavior	
	1	s joking, then a serious			management CQI tools will be	
	look came over he face. I asked [CNA				utilized by CEO/designee weekly	
	#2] when this happened and she replied				then monthly x2 then quarterly x3	3
	around 4:30 pm that day. I educated				to monitor for compliance and if 100% of threshold not met action	s
	[CNA #2] that sl	he needed to report it as			plans will be developed.	
		ned so it could be taken				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155377	A. BUI	LDING	00	COMPLI 11/18/20	
		100011	B. WIN			11/10/20	711
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR		
SEYMOL	JR CROSSING				OUR, IN47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID		Ī	(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	care of then, do not wait til (sic) end of				4. The Executive		
	shift. Told [CNA #2] to write a				Director/Designee will monitor for		
	statement. Took statement and called				compliance of audits in the daily C stand-up meeting.	ĮA	
	DON @ that time."				Stand-up meeting.		
	A : 1				5. All audit results will be		
	A signed statement from CNA #2				reviewed in the quarterly QA		
	_	A #1] made a sexual			meeting with the Medical Director	r.	
	-	Resident 'G']. She					
		the buttox (sic) while					
		im and asked him "if he			D. This plan of correction		
		en said yes, and she said			constitutes our credible allegation		
		do it again then?" And			of compliance with all regulatory		
		ssed this at approx. 4:30			requirements, out date of completion is:		
	pm."				completion is:		
		0.0074.004			12/17/11.		
	_	ent from CNA #1					
		s turning [Resident 'G']					
		im. And get him ready					
		ly whenever I turn him he					
	_	l hollering that I am					
	_	as surprised that last nite					
		ot doing any of that. I					
	0 3 1	tapped his buttocks, & I					
		as hurting him. He said					
		I told him no that I					
		lo it. But [Resident 'G'] if					
		and using the draw sheet					
		you are screaming &					
	_	hat I am hurting you, why					
	isn't that patting you don't hurt."						
	2. Resident 'A's record was reviewed on						
	11/17/11 at 2:31 p.m. The record						
		-					
		nt 'A' was admitted with					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377			LDING	NSTRUCTION  00	(X3) DATE COMPL 11/18/2	ETED	
NAMEOUS	ADOLUDED OF GUIDA TO		D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C			ACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMO	OUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	regulatory or LSC identifying information) diagnoses that included, but were not			TAG	DEFICIENC!)		DATE
	limited to, hearing impairment, high blood pressure, dementia, mild cognitive impairment, delirium related to multi-etiology, and agitated depression.						
	indivi viciogi, u	ug.v u-pr-0001011.					
	A quarterly mini	mum data set assessment,					
		idicated Resident 'A' was					
	able to make self						
	understands other	ers, had minimal difficulty					
	_	nearing aid, and was					
		ired - decisions poor;					
		required in cognitive					
	skills for daily d	ecision making.					
	Nurse's notes da	ated 11/3/11 at 6:35 p.m.,					
	1	ed to resident room to					
		] in bed [with] resident					
	_	ere down to ankles and					
		own but depends were on					
	_	ere embracing each other					
	& making move	ments with their lower					
	bodies. Residen	ts were separated.					
	Resident states s	he does not know how					
		wn. Male resident thinks					
		Male resident moved to					
	another wing &						
	_	to toe assessment done					
		vitals wnl (within					
	normal limits) [n						
		stress. Male resident had					
		nurse's station at 1820					
	(6:20 p.m.)"						

PRINTED: 12/19/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE COMPL		
111,1212111	or conditions	155377		LDING		11/18/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIER				ACKSON PARK DR		
SEYMOU	JR CROSSING				DUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCI)		DATE
	,	stigation of this incident					
		n and signed statement					
		as working C-wing with					
	_ ·	esident 'B'] on 15 minute					
		t incident of sexual					
	-	n] female resident was					
		ng R/T (related to)					
		0 (6:20 p.m.) [Resident					
		s desk observed by nurse					
		CNA's was going to take					
		7 minutes later was					
	1 2 3 2	to C wing. Came					
		that while CNAs where					
	' '	ther resident] down					
	[Resident 'B'] had						
	-	oom and was in bed with					
		(sic) [name of roommate]					
	_	o get nurse because there					
	_	in in bed with her					
		parking like a dog. [LPN					
	_	oom at 1835 (6:35 p.m.)					
		lents with pants down to					
	-	at 'A'] had depend on. I					
		sident's embracing each					
		& moving lower bodies					
		no penetration was					
		parated resident's and					
		s to ensure safety. DON					
	_	sing] & social services all					
	· ·	notified. Head to toe					
		ne on both [no] injuries.					
		ought [Resident 'A'] was					
	_	ent 'B'] was taken to D					
	wing and put on	one & one					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

P7G611

Facility ID: 000272

If continuation sheet

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155377			A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING  (X3) DATI COMP 11/18/				
	IDER OR SUPPLIER		J. WIIV	STREET A	DDRESS, CITY, STA			
SEYMOUR (	CROSSING			SEYMO	UR, IN47274			
(X4) ID PREFIX TAG	(EACH DEFICIENCE REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVI CROSS-REFERENCE	LAN OF CORRECTION E ACTION SHOULD BE ID TO THE APPROPRIAT CIENCY)	E	(X5) COMPLETION DATE
The wind state of the state of	ritten and signe (as follows: "Com.) I was work (b)-Wing" when proached me as arse for "C-Wing" that asked whom the command is the command in	s still wearing a depends I aside so as to appear it d. Together [RN #4] nt 'B'] from bed, dressed in W/C and placed him at th CNA. Head to toe diately and incident Resident ['B'] was om by approximately ."  rogress Notes, dated .m., indicated: "SS visited [with Resident sitting in chair smiling.	P7G611	Facility II	D: 000272	If continuation sh	eet Pai	ge 35 of 46

P7G611

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	COMPL		
MINDIEMIN	or conduction	155377		LDING		11/18/2	
		10077	B. WIN		DDDESS CITY STATE 7ID CODE	1171072	
NAME OF F	PROVIDER OR SUPPLIER				ACKSON PARK DR		
SEYMOU	JR CROSSING				UR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1710		red as to any concerns		1710			DATE
	•	ing. Writer inquired as					
		visitors last night -					
	_	No". Writer inquired as if					
	_	ned her in anyway					
		voices "No". Writer					
		knew year or day, voices					
	•	aired as to if she felt					
	afraid of, anyone	e at facility voices No,					
	No S/S of distres	s noted - pleasant,					
	smiling"						
	On 11/17/11 at 3	:30 p.m., the Social					
	Services Director	r indicated Resident 'A'					
	has shown no sig	ens of distress from this					
	incident at any ti	me.					
		0:40 a.m., the Director of					
		indicated the residents					
		ately separated by LPN					
		d them in the same bed,					
	and LPN #3 was						
		supposed to carry a					
		him and he didn't have					
		he had to go out of the					
	· ·	e residents together,					
	while he paged a	nurse on another hall.					
	This federal tag :	relates to Complaint					
	IN00099853.	ciaco to Compianit					
	1100077000.						
	3.1-28(c)						
	3.1-28(d)						

PRINTED: 12/19/2011 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER SETYMOUR CROSSING  SUMMAN STATEMENT OF DEFICIENCES (ACAT DEPICIENCY MUST BE PERCEDED BY PULL TAG  THE facility must develop and implement written policies and procedure in the provider of residents and misappropriation of resident property. Based on record review and interview, the facility lailed to ensure staff followed policy and procedure to protect a resident from abuse (Resident A) by immediately removing the abuser (Resident B). The facility also failed to ensure staff followed policy and procedure to report immediately to the supervisor when CNA #2 observed CNA #1 sexually abuse a resident. (Resident G) This deficient practice affected 2 of 5 residents reviewed for abuse in a sample of 7. (Resident A) and G)  Findings include: A document titled "Abuse Prohibition, Reporting, and Investigation Policy and		T OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO. LDING	00	(X3) DATE S COMPL	ETED
ESYMOUR CROSSING    NA) ID   REGILATORY OR LISC IDENTIFYING INFORMATION    PREPEX TAG   REGILATORY OR LISC IDENTIFYING INFORMATION    TAG   REGILATORY OR LISC IDENTIFY OR LISC I			155377	1			11/18/20	011
FO226 SS=D  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure staff followed policy and procedure to protect a resident from abuse (Resident A) by immediately removing the abuser (Resident B). The facility also failed to ensure staff followed policy and procedure to report immediately to the supervisor when CNA #2 observed CNA #1 sexually abuse a resident. (Resident G) This deficient practice affected 2 of 5 residents reviewed for abuse in a sample of 7. (Residents A and G)  Findings include:  A document titled "Abuse Prohibition, Reporting, and Investigation Policy and  FO226  FO226  FO226  FO226  F-226 Develop/ implement abuse/ neglect, etc policies.  The facility's intent is to develop/ implement abuse/ neglect, etc policies.  The facility intent is to develop/ implement abuse/ neglect, etc policies.  The facility intent is to develop/ implement abuse/ neglect, etc policies.  The facility intent is to develop/ implement abuse/ neglect, etc policies.  The facility intent is to develop/ implement abuse/ neglect, etc policies.					707 S J	ACKSON PARK DR		
A document titled "Abuse Prohibition, Reporting, and Investigation Policy and  2. Resident indicated is no longer	SEYMOU (X4) ID PREFIX TAG	The facility must downten policies and mistreatment, negland misappropriati Based on record of facility failed to expolicy and proced from abuse (Resiremoving the abut facility also failed policy and proced immediately to the #2 observed CNA resident. (Reside practice affected for abuse in a san and G)	evelop and implement diprocedures that prohibit ect, and abuse of residents on of resident property. The review and interview, the ensure staff followed dure to protect a resident dent A) by immediately user (Resident B). The dito ensure staff followed dure to report the supervisor when CNA A #1 sexually abuse a tent G) This deficient 2 of 5 residents reviewed imple of 7. (Residents A		STREET A 707 S J/ SEYMO ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  F-226 Develop/ implement abuse, neglect, etc policies  The facility's intent is to develop/ implement abuse/ neglect, etc policies.  A. ACTIONS TAKEN:		COMPLETION DATE
a resident at the facility.		A document titled	d "Abuse Prohibition,			facility.  2. Resident indicated is no long	ger	
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: P7G611 Facility ID: 000272 If continuation sheet Page 37 of 46	EODM CMS 2	567(02 00) Provious V	ng Ohoalata Evant ID: 5	70044	Eggilitz I	·	neat D	72 of 40

P7G611

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					ONSTRUCTION 00	(X3) DATE S COMPLI	
ANDILAN	or connection	155377		LDING		11/18/20	
		100011	B. WIN		A DDDDDGG GWWY GW WD	11/10/20	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR		
SEYMOL	JR CROSSING				OUR, IN47274		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		an effective date of					
	1	rovided by the Executive					
	Director on 11/1	7/11 at 10:12 a.m. The			B. OTHERS IDENTIFIED:		
	policy indicated,	, but was not limited to:					
	"It is the policy of	of American Senior					
	Communities to	protect residents from					
	abuse including	physical abuse, sexual			1. All residents have the		
	abuse, verbal ab	use, mental abuse,			potential to be affected		
	neglect, involun	tary seclusion, and			Resident interviews compl	eted	
	misappropriation	n of resident property			to ensure that they felt safe in th		
		exual Abuse - includes but			home.		
	is not limited to,	sexual harassment,					
		or sexual assault1.			3. 100% audit of the behavior		
	-	r Communities will not			monitoring record completed to		
		to be subjected to abuse			identify any other residents with sexual behaviors towards other		
	1 *	iding employees, other			residents or staff.		
		ltants, volunteers1. Any			residents of starr.		
	individual who	•			4. All staff in-service on, abus	e	
	resident-to-resid				prohibition, reporting, and		
		parate the residents			procedure as well as identifying a		
	involved. 2. the				monitoring inappropriate behavio	ors	
					scheduled on 12/13/11 by ADNS /SSD or designee with a post test		
		ouse will report the			7 Job of designee with a post test		
	situation immed	•					
	•	resident(s) involved in be removed from the					
					C. MEASURES TAKEN:		
	situation immed	iatery					
	1 Dagidant Ma	roand was ravioused on					
		record was reviewed on			Any residents identified, ca	ire	
		p.m. The record			plans / CNA. assignment sheets a	nd	
		ent 'A' was admitted with			current interventions will be		
	1	ncluded, but were not			reviewed/ updated.		
	-	ng impairment, high			2 All staff in an		
	•	dementia, mild cognitive			<ol><li>All staff in-service on, abus prohibition, reporting, and</li></ol>	e	
	impairment, deli	rium related to			promonion, reporting, and		
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155377	B. WIN			11/18/2011
					ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF I	PROVIDER OR SUPPLIER	R		707 S J	ACKSON PARK DR	
SEYMOL	JR CROSSING			SEYMC	OUR, IN47274	,
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	multi-etiology, a	and agitated depression.			procedure as well as implementin	-
					appropriate behavior intervention and monitoring scheduled on	1
		imum data set assessment			12/13/11 by ADNS or designee wi	th
	dated 9/26/11 in	dicated Resident 'A' was			a post test, this will be completed	
	able to make sel	f understood and			a monthly basis until discontinued	
	understands other	ers, had minimal difficulty			by facility QA committee.	
	hearing, used a h	nearing aid, and was				
	moderately impa	aired - decisions poor;			<ol> <li>Behavior monitoring tools v</li> </ol>	vill
		required in cognitive			be reviewed with IDT team daily	
	skills for daily decision making.				during daily clinical QA meeting.	
					4. Abuse prohibition and	
	Nurse's notes da	ted 11/3/11 at 6:35 p.m.			investigation psychoactive	
		ed to resident room to			medication/ behavior manageme	nt
		'] in bed [with] resident			CQI tools will be utilized weekly x	
	_	= = =			then monthly x2 then quarterly x3	3
		rere down to ankles and			to monitor for compliance and	
	-	own but depends were on			actions plans will be developed as	5
		ere embracing each other			identified.	
	_	ments with their lower			5. All allegations of abuse or	
		ts were separated.			neglect will be reported to ED or	
		she does not know how			designee upon occurrence.	
		wn. Male resident thinks			Investigation will be initiated	
		Male resident moved to			resident assessments, staff reside	nt
	another wing &	is on one-to-one			interviews, psychosocial monitori	=
	supervision head	d to toe assessment done			and updates to plan of care will be	
	on [Resident 'A']	] vitals wnl (within			completed. Resident physician ar	nd
	normal limits) [r	no] s/s (signs or			family will be notified.	
	symptoms) of di	stress. Male resident had			Resident safety will be maintained	d at
		t nurse's station at 1820			all times. Non compliance with	
	(6:20 p.m.)"				reporting and or protecting may	
	1,,				result in disciplinary action up to	and
	The facility inve	estigation of this incident			including termination.	
		en and signed statement				
		Vas working C-wing with			6. Audit across all shifts by	
		Resident 'B'] on 15 minute			charge nurse or designee to moni	tor
	(two CNAS) - [N	Colucii D J On 13 minute			staff - resident interaction for	

000272

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	A. BUI	LDING	ONSTRUCTION 00	(X3) DATE COMPL 11/18/2	ETED
		155577	B. WIN			11/10/2	011
	PROVIDER OR SUPPLIEF JR CROSSING	3		707 S J	ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR DUR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
	misconduct [with	t incident of sexual h] female resident was ing R/T (related to)			appropriateness continued unti discontinued by CQI committee		
	'B'] was at nurse & CNA's. I told	20 (6:20 p.m.) [Resident s desk observed by nurse CNA's was going to take . 7 minutes later was			D. <b>HOW MONITORED</b> :		
	paged by [LPN # back to discover (sic) laying [ano [Resident 'B'] ha [Resident 'A's] reher. Roommate went to D wing was a strange maroommate (sic) be #5] went to the reto find both resident ankles. [Resident observed both resident other with arms as if having sext took proper step & social services notified. Head to no both [no] injuthought [Resident in the continuation of the contin	that while CNAs where ther resident] down d wheeled self to com and was in bed with (sic) [name of roommate] to get nurse because there an in bed with her barking like a dog. [LPN com at 1835 (6:35 p.m.) dents with pants down to nt 'A'] had depend on. I esident's embracing each & moving lower bodies no penetration was aparated resident's and so to ensure safety. DON is all family members to toe [assessment] done tries. [Resident 'B'] int 'A'] was his wife.			1. Resident interviews will be completed to monitor for compliance. Also random empliaudits will be completed to ensistaff compliance and understan of abuse prohibition policy by the SSD/designee weekly x4 then monthly x2 then quarterly x3 to monitor for compliance and if 1 of threshold not met actions play will be developed.  2. Any inappropriate behavior will be reported to the nurse the reviewed in the daily clinical QA meeting.  3. Abuse prohibition and investigation, Abuse prohibition psychoactive medication/ behavior management CQI tools will be utilized by CEO/designee weekly then monthly x2 then quarterly to monitor for compliance and it 100% of threshold not met action plans will be developed.	oyee ure ding ne 00% ans ors en a, and vior y x4 x3 f	
	written and sign	stigation included a ed statement from LPN On this date at 1835 (6:35			<ol> <li>The Executive         Director/Designee will monitor compliance of audits in the daily stand-up meeting.     </li> </ol>		

Facility ID:

	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE PLAN OF CORRECTION IDENTIFICATION NUMBER: 4. BUILDING B. WING		LDING	NSTRUCTION  00	CON	TE SURVEY MPLETED 8/2011	
	PROVIDER OR SUPPLIER	<u>1</u>	b. WIN	STREET A	DDRESS, CITY, STATE, ZIP CO ACKSON PARK DR UR, IN47274	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	approached me a nurse for "C-Wii not, but asked w	[Resident 'A's roommate] and asked if I was the ng". I informed her I was that she needed. She then t "There is a strange man			5. All audit results will reviewed in the quarterly meeting with the Medical	QA Director.	
	room mate." I ir [number of room [Resident 'B'] lay 'A']. I immediate	ying in bed with [Resident ely paged "C-Wing nurse			D. This plan of correction constitutes our credible a of compliance with all regrequirements, out date or completion is:	llegation gulatory	
	found both [Resi undressed from t [Resident 'B'] wa	ident 'B' and Resident 'A'] the waist down. as still wearing a depends d aside so as to appear it			12/17/11.		
	had been remove removed [Reside him, placed him nurses station wi	ed. Together [RN #4] ent 'B'] from bed, dressed in W/C and placed him at ith CNA. Head to toe					
	report initiated.	ediately and incident Resident ['B'] was from by approximately b."					
	11/4/11 at 6:55 a visited [with Res sitting in chair si	rogress Notes, dated a.m., indicated: "SS sident 'A'] at this time. miling. This writer y concerns voices "No"					
	smiling. Writer any visitors last "No". Writer ind	inquired as to if she had night - smiling voices quired as if anyone had nyway inappropriately,					
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE : COMPL		
7 IND I EAR	or connection	155377	A. BUI B. WIN	LDING		11/18/2	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				ACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMO	UR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1710		riter inquired to if she		1110			BITTE
		y, voices "No" writer					
	1	she felt afraid of, anyone					
		No, No S/S of distress					
	noted - pleasant,	smiling"					
		:30 p.m., the Social					
		r indicated Resident 'A'					
		gns of distress from this					
	incident at any ti	me.					
	On 11/18/11 at 1	0:40 a.m., the Director of					
		indicated the residents					
		ately separated by LPN					
		d them in the same bed,					
	and LPN #3 was	-					
	indicated he was	supposed to carry a					
	walkie talkie on	him, and he didn't have					
	his with him, so	he had to go out of the					
	room, and left th	e residents together,					
	while he paged a	nurse on another hall.					
		record was reviewed on					
		0 p.m. The record nt 'G' was admitted with					
	1	cluded, but were not blood pressure, left sided					
	_	inia, depression, and					
	anxiety.	inia, acpression, and					
	A quarterly mini	mum data set assessment					
	dated 10/14/11 in	ndicated Resident 'G' had					
	_	de himself understood,					
	understands othe	ers, and had modified					

000272

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	00	COMPL	
ANDILAN	OF CORRECTION	155377	A. BUI	LDING		11/18/2	
		133377	B. WIN			11/10/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SEYMOU	JR CROSSING				ACKSON PARK DR DUR, IN47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	cognitive skills for daily					
	decision making.						
	Social Service N	otes dated 10/7/11 at					
		ed: "SS spoke [with					
		his time as to any					
	_	to his care. [Resident					
		0/6/11 around 5PM - he					
		a CNA patted his bottom					
		he liked it - resident					
		m uncomfortable. And					
	he didn't want it						
		ne didn't want any one in					
		nce provided and assured					
		d be investigated"					
	ins concern wou	a oo mvostigatea					
	A care plan, date	d 10/7/11, indicated:					
	"Problem: I was	patted on my bottom on					
	10/6/11 it made 1	ne feel uncomfortable.					
	Goal: I will be c	omfortable in my care					
	TNR (through ne	ext review) Interventions:					
	(1) Reassure (2)	Encourage to vent					
	feelings (3) Noti	fy POA [power of					
	attorney], MD. (4	4) Resident and POA					
	does not wish to	press charges. (5) Calm					
	environment (6)	explain procedures prior					
	to care"						
	1	ent Reporting Form"					
	indicated: "Brief	f Description of Incident:					
	[CNA #2] report	ed during care [CNA #1]					
	patted [Resident	'G'] on the buttocks.					
	'- ' '	njuries: None. Immediate					
	Action Taken: [0	CNA #1 and CNA #2]					

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	LDING	NSTRUCTION 00	(X3) DATE COMPL 11/18/2	ETED
	PROVIDER OR SUPPLIER JR CROSSING	<b>.</b>	 STREET A	DDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR UR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	(X5) COMPLETION DATE
	Shift to Shift 100 Abuse and Repo immediately. Re Investigation corresident interview reported at the enurse that at app witnessed [CNA the buttocks and and proceeded to buttocks. After did state he did ragain. Plan of A [CNA #1 and 2] and Abuse Insert The facility investinct and approx. 9:55 planeded to talk [with drsg. change on a completed my tastation and began after, [CNA #2] nurse's station arwent to her. She knew she was suasked her what we by telling me that sexual gestures to	eventive measures taken:  0% all staff inservice on rting initiated esults of Investigation: mplete, Staff statements, ws collected. [CNA #2] and of her shift at 10 pm to roximately 4:30 pm she  #1] pat [Resident 'G'] on asked him if he liked it to pat him again on the interviewing resident, he not want it to happen action/Interventions: to both be terminated,				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/18/2011	
NAME OF PROVIDER OR SUPPLIER SEYMOUR CROSSING				707 S J	DDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR UR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	then asked him is said yes, she did was as if she was look came over 1 #2] when this has around 4:30 pm [CNA #2] that she soon as it happed care of then, do shift. Told [CNA statement. Took DON @ that time.  A signed statement indicated: "[CNA gesture toward [Smacked him on were changing has liked it"? He then "oh really, can I she did. I witness pm."  A signed statement indicated: "I was over to change has for bed. Normal is screaming and hurting him. Was gently patted or asked him if I was no gently patted or asked him if I was not gently patted or gentl	statement and called					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155377		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY  COMPLETED  11/18/2011	
NAME OF F	PROVIDER OR SUPPLIEF	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
SEYMOL	JR CROSSING			JACKSON PARK DR DUR, IN47274	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	I am turning you to turn you and y hollering at me t isn't that patting	lo it. But [Resident 'G'] if and using the draw sheet you are screaming & hat I am hurting you, why you don't hurt."  relates to Complaint			